

## PRE-REGISTRATION PARTICIPANT FORM

# Rutherford Co Senior Center Health Fair & Flu Clinic

Date: Thursday, October 29, 2015 ~ Time: 8:30 a.m. – 11:30 a.m.

**\*\* All Information on this form is kept Confidential \*\***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #(S): \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone #(s): \_\_\_\_\_

How Would You Rate Your Overall Health Status: ☐ Well ☐ At Risk ☐ High Risk ☐ Not Sure

Primary Care Physician: \_\_\_\_\_ Other Physician(s): \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Allergic To: \_\_\_\_\_

Major Health Issues: \_\_\_\_\_

*\* continue answers on back of page if more room is needed for above questions*

### I PLAN ON PARTICIPATING IN THE FOLLOWING SERVICES (list all that are applicable):

\_\_\_\_\_ Extensive Blood Profile \_\_\_\_\_ Flu Shot \_\_\_\_\_ Free Screenings/Info.  
(\$ 9.00 donation requested) (\$32.00 for those without Medicare or see Angela Ezell\*)

- If you plan on having the **BLOOD PROFILE**, you must be **FASTING** (no food or drink after midnight)
- If you plan to receive a **FLU SHOT**, **BE SURE TO HAVE YOUR BLOOD TEST FIRST**

Please Note: The Health Fair screening tests do not replace a physical examination by your physician.  
The Health Fair program cannot give you a "clean bill of health." This is the responsibility of your physician.  
You are responsible for contacting your personal physician(s) with your screening results.

### CONSENT AND RELEASE STATEMENT

I hereby release the Rutherford County Department of Aging, The Rutherford County Health Department, and the other agencies represented at the 2015 Health Fair & Flu Clinic from any and all liability, including any matter or thing committed or omitted which may arise during blood drawing or other examinations/tests or from the data derived there from. It is understood that:

1. The Screening Tests are to be considered as preliminary, and is in no way conclusive. The Health Fair screenings do not replace a physical examination by my physician.
2. Any follow-up examinations for abnormalities identified at the Screening lies with me as the person responsible for my own health.
3. My test results may be viewed for the sole purpose of ascertaining if the results are abnormal and aiding me in initiating a follow-up exam.
4. All information will be kept confidential, and no one over 60 will be denied services because of inability to pay.

I have read and understand the above statements.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)